Healthcare Analytics in Navy Medicine
Perspectives and Methods for Decision-Making

FOCUS ON ACCESS AND THE NDAA

The National Defense Authorization Act (NDAA)'s Impact on Access

The National Defense Authorization Act (NDAA) is the annual authorization bill for the Department of Defense (DoD) and covers all aspects of DoD programs. Specific sections deal with the Defense Health Program (DHP) and operations. This article details specific DHP policy and programmatic changes specified in Fiscal Year 2017 and 2018 NDAAs impacting access to quality health services.

Background

The NDAA is passed every year by Congress and signed into law by the President, specifying the budget and expenditures of the DoD. This legislation determines the agencies responsible for defense, establishes funding levels, and sets the policies under which money will be spent. Each year, sections of the law specify policies and funding for the DHP. The year noted in the law's title represents the fiscal year of DoD program operation.

Usually, important but incremental DHP benefit and operational changes are specified by Congress from year-to-year. However, the NDAA Fiscal Year 2017 (NDAA17) included significant reorganizational changes to the DHP and changes to the TRICARE program. Specifically, NDAA17 dramatically changed the role of the Defense Health Agency (DHA) in managing the MTFs. The legislation noted that "a single agency responsible for the administration of all MTFs would best improve and sustain operational medical force readiness and the medical readiness of the armed forces, improve beneficiaries' access to care and the experience of care, improve health outcomes, and lower the total management cost of the military health system."

NDAA Fiscal Year 2018 (NDAA18) was less dramatic and included more of the incremental updates to benefits and DHP operations. More recently, the House Bill version of NDAA Fiscal Year 2019 (NDAA19) has passed the House and Senate and was voted out of Conference. It must pass a final vote later this year, usually in December. Then, it must be signed by the President to become law.

The sections below highlight some of the important impacts of recent NDAA legislation on access to expanded services and higher quality care.

Expanded Access to Urgent Care

Traditionally, TRICARE Prime enrollees needed a referral before seeing a civilian urgent care provider who was not their PCM. Visits to the emergency department were excluded from this referral requirement. Active Duty Family Members (ADFMs) and retirees also had the option of paying out-of-pocket to self-refer using Prime's point-of-service (POS) option.

As part of a NDAA Fiscal Year 2016 (NDAA16) requirement, in May 2016 DoD implemented a national demonstration allowing non-active duty Prime enrollees in the U.S. two self-referred network urgent care visits per year, without POS charges. NDAA17 made this change permanent and removed the two-visit limit, although early experience in the NDAA16 pilot (and an earlier Coast Guard pilot) indicated very few enrollees obtained more than two per year in any case. ADSMs and overseas enrollees still need a referral.

NDAA17 also required the MHS to expand after-hours access in the direct care system as part of another requirement to standardized MTF appointing. However,

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implementation details on how to implement this increased after-hours access have been left to DoD's discretion.

Requirements for Standardized MTF Appointing

NDAA17 also required a comprehensive plan to implement a standardized appointment system and eliminate variance in the appointment scheduling processes. While much of the work necessary to meet this requirement is already being implemented,[1] the key points related to expanded direct care appointment access include:

- Expands appointment availability to meet MHS access standards.
- Expands MTF operating hours/days
- Establishes first call resolution process
- Establishes tighter appointment template control
- Expands walk-in care
- Makes follow-up appointment booking easier for patient

Expanded Access Standards for TRICARE Select

While the conversion of TRICARE Standard and TRICARE Extra to TRICARE Select, as well as the auto-enrollment to TRICARE Select, have probably received the most attention in NDAA17, this legislation also required beneficiary access standards for TRICARE Select. Specifically, the following standards were created:

- Ensure access standards for appointments for health care that meet or exceed those of high-performing health care systems in the U.S.
- Establish mechanisms for monitoring compliance with access standards.
- Establish health care provider-to-beneficiary ratios.
- Monthly monitoring of complaints by beneficiaries with respect to network adequacy and the availability of health care providers.
- Establish requirements for mechanisms to monitor the responses to complaints by beneficiaries.
- Establish mechanisms to evaluate the quality metrics of the network providers.

Implementation of these standards is still being done, and progress towards these standards has been slow and hindered by data and monitoring capabilities.[2]

Implementing Value-Based Purchasing Pilots

In an effort to expand access to value-based care, NDAA17 required DoD to implement value-based purchasing and value-based insurance design pilots meeting various specific requirements. To meet this requirement, DHA has been engaged with the Managed Care Support (MCS) contractors to discuss feasible pilots. Many concepts have been considered to date, and those that have been approved for initial implementation as of April 2018 include:

- **A medication adherence pilot** to test the effects of copays on medication adherence and associated outcomes. This national pilot will reduce the copay for the Lantus pen, which delivers insulin for diabetes, and will eliminate the copay for generic Crestor (i.e., brand-name Rosuvastatin for treatment of high cholesterol).
- **A performance-based maternity pilot (P-BMP)** to expand access to network hospitals who meet Leapfrog standards for selected maternity care quality metrics (e.g., early elective deliveries, C-sections, episiotomies, and maternity care processes). High-performing hospitals will receive special designations in the MCS contractor's network directory with the goal of increasing the share of purchased care deliveries that occur at those hospitals that perform well (or that have the best metrics, best quality of care). These hospitals will also receive slight increases in their reimbursement rate.
- **An online decision-support tool** to help educate beneficiaries for shared decision-making for a range of potential surgeries. This tool, details of which DHA is finalizing for a proposed test, will be administered by a vendor and tested in two local markets in the West.

Several other value-based purchasing pilots are also in various stages of development and consideration and are likely to roll out in the coming months and years.

1 https://health.mil/About-MHS/OASDHA/Defense-Health-Agency/Congressional-Relations/Reports-to-Congress

2 Government Accountability Office (April 2018). https://www.gao.gov/assets/700/691256.pdf

Expanded Virtual Health Services

NDAA17 also required DoD to expand access to virtual health services. DHA has submitted an interim Report to Congress describing a wide-range of existing and new virtual health efforts in the direct care system, as well as significant changes in virtual health access for purchased care.[3]

In direct care, the Services have combined virtual health efforts and are implementing an approved strategic plan that advances these services. Three main direct care initiatives include an improved global tele-consultation portal, virtual video visits, and remote health monitoring. For purchased care, one key change is that beneficiaries can receive a virtual health visit from his/her home, rather than having to travel to a virtual health site. A second key change is that TRICARE coverage of virtual health services was previously limited to a specified list of CPT codes for reimbursement. Now, however, TRICARE will cover those services previously only covered in a face-to-face visit as long as they are appropriate for virtual health based on industry standards.

Expanded Access to Specialized Devices, Products, and Services

Recent NDAA legislations also includes provisions that expand access to a number of devices, products, and services to special populations and treatment needs. A few examples include:

- **NDAA17 expanded provision of hearing aids to dependents of retired members**. Since the 1990s, retired beneficiaries have been able to get hearing aids at government costs through the Retiree At-Cost Hearing Aid Program, popularly known as RACHAP. RACHAP is now also available to dependents of former members of the uniformed Services.
- **NDAA17 expanded coverage of medically-necessary food for certain conditions under the TRICARE program**. Previously, coverage of medical-necessary food to treat TRICARE beneficiaries with inborn errors of metabolism (IEM) and related inherited disorders was mandated. While this coverage included medically-necessary formulas, vitamins and minerals for such patients, it did not cover foods such as flour, cereal, bread, rice, pasta, and meat substitutes that can cost five to ten times the amount of equivalent food products. NDAA17 extends coverage to these high-cost, medically-necessary products.
- **NDAA18 authorized Physical Therapist Assistants (PTAs) and Occupational Therapist Assistants (OTAs) to provide reimbursable services under the TRICARE Program**. Previously, TRICARE policy did not recognize PTAs and OTAs as TRICARE authorized providers. As a result, therapy services had to be provided by a PT, OT or other authorized TRICARE provider. The NDAA 17 added licensed or certified PTAs and OTAs who meet specified qualifications to the list of individual professional providers of care who are authorized to provide services to beneficiaries under the TRICARE program. Expanding authorized providers for these services may alleviate any small shortages of therapy providers that may exist in some areas and may allow for therapy appointments to be scheduled more efficiently.

Increases to Pharmacy Copays

While many NDAA requirements expand access to services, some may actually decrease access. For example, NDAA18 specified a ten-year ramp-up of pharmacy copays. This follows the precedent of several previous NDAA increases in pharmacy copays over the past six years (starting in FY12), as well as other earlier NDAA changes such as mandatory use of mail-order for most brand-name drugs not filled at an MTF.

The most significant copay change under NDAA18 is that mail-order generics will no longer be free for ADFMs and retirees. Instead, these beneficiaries will have a $7 copay for mail-order generics.

Summary

Each year, the NDAA legislation has many components that have the potential to increase or decrease access to specific health care programs and services. Closely monitoring these bills as they move through the legislative process continues to be important as leaders and planners consider future policy impacts on access and quality.

This article was written by Marty Cohen, PhD, Arnie Brooks, MPP, and Allison Russo, DrPH. The authors are senior staff at Kennell and Associates and are consultants for BUMED and the Defense Health Agency.

3 https://health.mil/About-MHS/OASDHA/Defense-Health-Agency/Congressional-Relations/Reports-to-Congress/Signed-in-2017

SKILLS AND METHODS

– *IMPROVING MTF APPOINTMENT SCHEDULING*

In response to NDAA 2017 requirement to implement a standardized appointing system and eliminate variance in appointment scheduling across all MTFs, the MHS has developed a comprehensive plan to address these issues. This article describes some of the universal processes that will be used to improve medical appointing.

While the MHS has made progress in standardizing appointing processes since 2012, variance remains in the execution of specific processes and procedures. NDAA 2017 attempted to address these issues by requiring the implantation of a standardized appointing system and scheduling across all MTFs. Some of the challenges in the existing appointing processes included variance in primary care appointment booking protocols and primary care appointment availability. For specialty care, there was very little uniformity of appointment types, appointing standards and processes to include how far out appointments are available in the future within specialty and behavioral health care. There was also little uniformity over the control of specialty care appointment templates.

Additionally, there was a misalignment of MTF appointment supply and demand. Primary, specialty and behavioral health care appointments were not always available on the days and times beneficiaries prefer to be seen. Challenges in this area included some MTFs being closed multiple days in a row adjacent to weekends and federal holidays and few MTF appointments available the last two hours of the day when beneficiaries wished to be seen after school or work.

To address these challenges, DoD developed a comprehensive plan that detailed new processes and accountability for standardized MTF appointing.[4] Detailed processes for both primary care and specialty care were outlined in this plan, but universal processes and procedures applied to primary, specialty and behavioral health care. These processes and procedures are outlined below.

- **Manual Appointing System** - The direct care system will continue using CHCS as the sole MHS appointment system to build templates and schedule appointments in MTFs until the transition to MHS Genesis is complete.
- **Appointment Availability to Meet MHS Access Standards** - MTFs will ensure a sufficient number of appointments are available in order to meet MHS Access Standards and will direct beneficiaries to Managed Care Support Contractor network providers when MTF care is not available or feasible.
- **MTF Operating Hours/Days** - MTFs will be open a minimum of nine hours (eight patient care hours plus one hour for lunch) Monday thru Friday. Any adjustments to core operating hours must align to the hours when beneficiaries prefer to be seen. Additionally, MTFs will offer additional extended operating hours Monday thru Friday beyond eight hours a day or on weekends where sufficient demand exists.
- **Consecutive Days Closed** - No MTF may close in excess of three days or any additional day beyond federally-declared holidays as identified by the Office of Personnel Management or the President of the United States.
- **First Call Resolution** - No Prime beneficiary will be asked to call back on another day to see if an appointment is available, and the direct care system will codify the standard processes for first call resolution of appointment requests.
- **Appointment Template Control** - Only clinic leadership and authorized individuals will have the ability to open, block, adjust, cancel or freeze appointment templates in primary, specialty and behavioral health care clinics.
- **Appointment Restrictions, Cancellations, and Freezing** - The MTF may not cancel more than three percent of appointments per month, not including weather-related cancellations, operational, or Accreditation Council for Graduate Medical Education (ACGME) compliance contingencies.
- **Walk-In Care** - MTFs will commit to accepting walk-in care for urgent reasons to the greatest extent possible.
- **Follow-up and Specialty Booking at Appointment Checkout** - If a follow-up appointment is clinically indicated in the professional judgment of the

4 Report on a Standardized System for Scheduling Medical Appointments at Military Treatment Facilities, July 2017. Accessed at https://health.mil/About-MHS/OASDHA/Defense-Health-Agency/Congressional-Relations/Reports-to-Congress

provider, the health care team will offer to schedule the beneficiary a follow-up appointment at checkout prior to the beneficiary departing the MTF.

- **Missed or Late Appointments** - The direct care system defines a missed appointment as an appointment for which the beneficiary is not present or when the beneficiary is more than ten minutes late for the scheduled appointment time. If the beneficiary arrives more than ten minutes late, the MTF will offer to work the beneficiary in with the same or a different provider before the end of day.
- **Telephone Appointing** - Primary care appointing staff will adhere to standard processes, regardless of whether MTF appointing is centralized or decentralized.
- **Post-Discharge Appointment Booking** - All beneficiaries discharged from the MTF following admission will be booked for a follow-up appointment in either specialty care or primary care prior to departing the MTF.
- **Stakeholder Education** - The direct care system will implement a beneficiary education campaign plan informing beneficiaries about the various ways in which beneficiaries may schedule MTF primary, specialty and behavioral health care appointments, including through the use of secure messaging and the TRICARE Online (TOL) Patient Portal.

DATA AND INFORMATION SYSTEMS

– *TRICARE OPERATIONS CENTER (TOC)*

This section provides an overview of the TRICARE Operations Center (TOC) and a description of helpful TOC reports.

Federal law states that TRICARE Prime beneficiaries receive acute medical care within 24 hours for an acute issue, routine care within 7 calendar days, and wellness or specialty care within 28 calendar days within direct care or purchased care. The TRICARE Operations Center (TOC) provides reports that evaluate direct care facilities' adherence to access standards and how often patients see their Primary Care Manager (PCM) using appointment and enrollment data from CHCS. For those sites that have already transitioned to MHS Genesis from CHCS/AHLTA, work is underway to collect the necessary data from MHS Genesis to measure performance at all MTFs, regardless of which EHR they are using. So far, a beta version of the PCM Continuity report has been created from MHS Genesis data, but it has not been fully vetted and combined with data from CHCS/AHLTA.

The reports on the TOC are in an easily downloadable Excel format and allow users to drill down by service to individual command, DMIS ID, clinic, CHCS provider ID, or enrollment program category, including TRICARE Prime, TRICARE Plus, and TRICARE Select. Reports from the TOC also feed a variety of metrics on the MHS Dashboard. A discussion of three helpful TOC reports follows below.

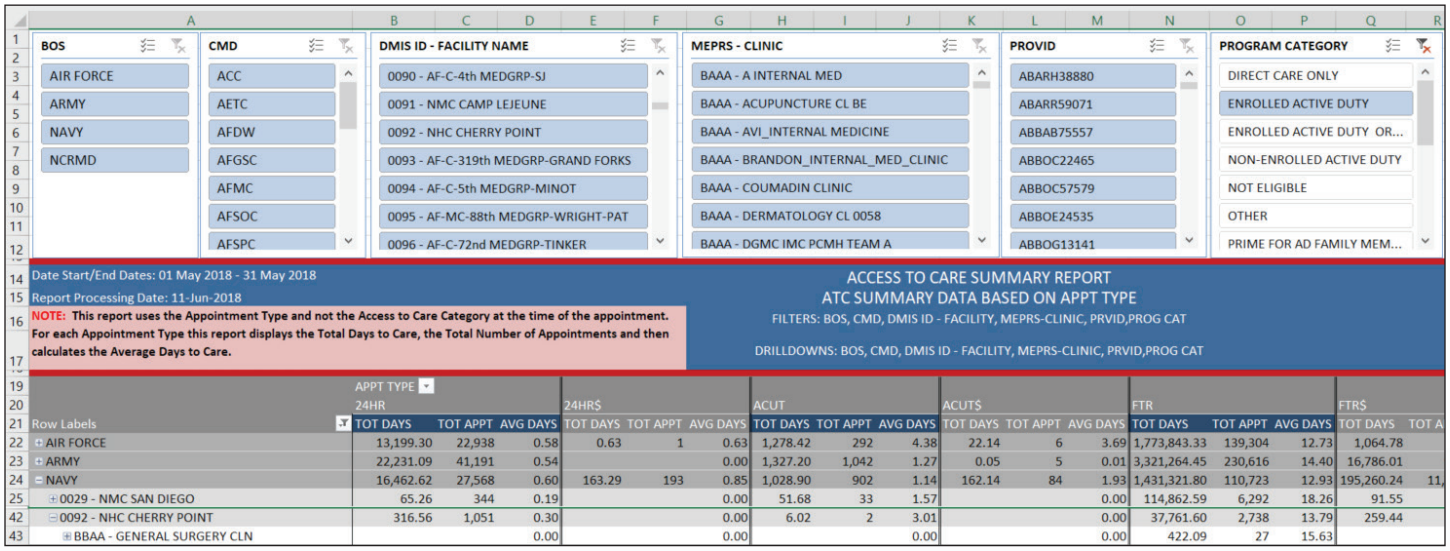
ATC Summary Report

The Access to Care (ATC) Summary report has drill down capability with a series of Excel slicer menus at the top of the report or in a series of drop down menus within the report. This report shows a monthly retrospective look at the total number of appointments by appointment type, including 24 HR, ACUT, FTR, GRP, PCM, PROC, ROUT, SPEC, and WELL. The total number of appointments for the prior month is divided by the total days between when appointments were made to the actual appointment dates to get an average number of days to an appointment. Appointments with mental health diagnoses are broken out in a separate tab of the ATC Summary report.

Some appointments are excluded from the ATC Summary report to better reflect the appointments an MTF has planned for and its efforts to meet ATC standards. Appointments within access standards that a patient has refused during booking, as well as appointments a facility has had to cancel but that have been rebooked, are excluded from the report. Since access standards apply only to Prime beneficiaries, a drill-down to include only records for Prime beneficiaries is available.

An example of the ATC Summary Report and the different ways of drilling down in the report is shown in Figure 1.

Figure 1. ATC Summary Report Example



BOS	CMD	DMIS ID - FACILITY NAME	MEPRS - CLINIC	PROVID	PROGRAM CATEGORY
AIR FORCE	ACC	0090 - AF-C-4th MEDGRP-SJ	BAAA - A INTERNAL MED	ABARH38880	DIRECT CARE ONLY
ARMY	AETC	0091 - NMC CAMP LEJEUNE	BAAA - ACUPUNCTURE CL BE	ABARR59071	ENROLLED ACTIVE DUTY
NAVY	AFDW	0092 - NHC CHERRY POINT	BAAA - AVI_INTERNAL MEDICINE	ABBAB75557	ENROLLED ACTIVE DUTY OR...
NCRMD	AFGSC	0093 - AF-C-319th MEDGRP-GRAND FORKS	BAAA - BRANDON_INTERNAL_MED_CLINIC	ABBOC22465	NON-ENROLLED ACTIVE DUTY
	AFMC	0094 - AF-C-5th MEDGRP-MINOT	BAAA - COUMADIN CLINIC	ABBOC57579	NOT ELIGIBLE
	AFSOC	0095 - AF-MC-88th MEDGRP-WRIGHT-PAT	BAAA - DERMATOLOGY CL 0058	ABBOE24535	OTHER
	AFSPC	0096 - AF-C-72nd MEDGRP-TINKER	BAAA - DGMC IMC PCMH TEAM A	ABBOG13141	PRIME FOR AD FAMILY MEM...

Date Start/End Dates: 01 May 2018 - 31 May 2018
Report Processing Date: 11-Jun-2018
NOTE: This report uses the Appointment Type and not the Access to Care Category at the time of the appointment. For each Appointment Type this report displays the Total Days to Care, the Total Number of Appointments and then calculates the Average Days to Care.

ACCESS TO CARE SUMMARY REPORT
ATC SUMMARY DATA BASED ON APPT TYPE
FILTERS: BOS, CMD, DMIS ID - FACILITY, MEPRS-CLINIC, PRVID,PROG CAT
DRILLDOWNS: BOS, CMD, DMIS ID - FACILITY, MEPRS-CLINIC, PRVID,PROG CAT

APPT TYPE	24HR			24HR$			ACUT			ACUT$			FTR			FTR$	
Row Labels	TOT DAYS	TOT APPT	AVG DAYS	TOT DAYS	TOT APPT	AVG DAYS	TOT DAYS	TOT APPT	AVG DAYS	TOT DAYS	TOT APPT	AVG DAYS	TOT DAYS	TOT APPT	AVG DAYS	TOT DAYS	TOT A
⊞AIR FORCE	13,199.30	22,938	0.58	0.63	1	0.63	1,278.42	292	4.38	22.14	6	3.69	1,773,843.33	139,304	12.73	1,064.78	
⊞ARMY	22,231.09	41,191	0.54			0.00	1,327.20	1,042	1.27	0.05	5	0.01	3,321,264.45	230,616	14.40	16,786.01	
⊟NAVY	16,462.62	27,568	0.60	163.29	193	0.85	1,028.90	902	1.14	162.14	84	1.93	1,431,321.80	110,723	12.93	195,260.24	11
⊞0029 - NMC SAN DIEGO	65.26	344	0.19			0.00	51.68	33	1.57			0.00	114,862.59	6,292	18.26	91.55	
⊟0092 - NHC CHERRY POINT	316.56	1,051	0.30			0.00	6.02	2	3.01			0.00	37,761.60	2,738	13.79	259.44	
⊞BBAA - GENERAL SURGERY CLN			0.00			0.00			0.00			0.00	422.09	27	15.63		

Third Next Available Report

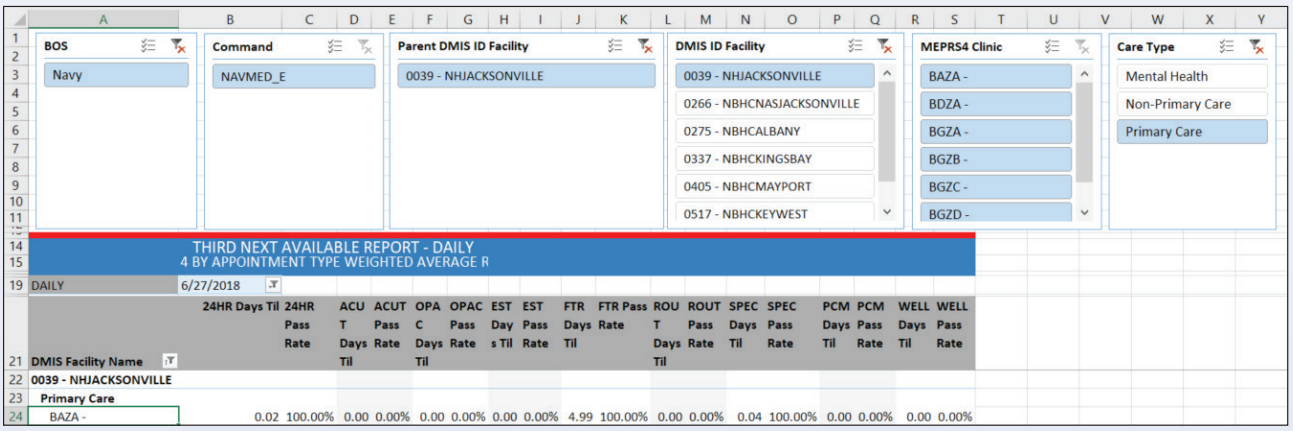
The TOC offers a monthly, weekly, and daily report showing appointment availability and posture to meet access to care standards by capturing when a third appointment of a certain type is available. This report includes options to view metric scores by service, command, parent DMIS ID, child DMIS ID, clinic, and care type, including mental health, specialty care, and primary care on various tabs. The Third Next Available report does not include sites that have transitioned to MHS Genesis starting two months prior to when the MTF transitioned.

The third open appointment slot in each clinic for a given appointment type is the Third Next Available Appointment. The days until third next is counted from 8:30 am of a given observation day to that third next appointment. That number of days (or hours) is compared to the access standard for a given appointment type to determine if the clinic "passes" or meets those access standards.

The days until third next appointment and the pass rate are both aggregated across clinics by day, by week, and by month. The averages are weighted by the relative size of the clinics in a given MTF, command, or service. The size of each clinic is measured by the total number of booked and open appointment slots (for a given appointment type) on a given observation date. An example of the daily, weekly, and monthly Third Next Available reports are shown in Figures 2-4.

The TOC also includes separate monthly and weekly reports showing how often providers' schedules meet the third available standard. Looking at the Detailed Provider Schedule "Days To" weekly report can indicate if providers have enough appointment availability to meet access standards.

Figure 2. Daily Report Example



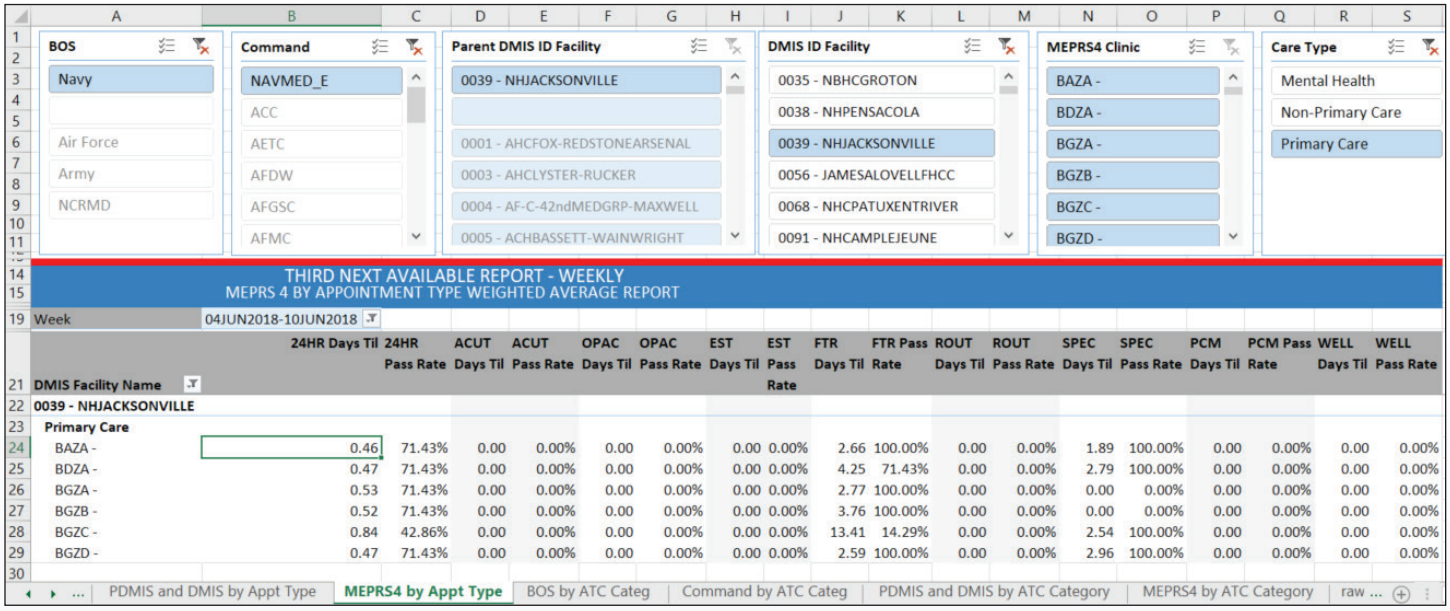
BOS	Command	Parent DMIS ID Facility	DMIS ID Facility	MEPRS4 Clinic	Care Type
Navy	NAVMED_E	0039 - NHJACKSONVILLE	0039 - NHJACKSONVILLE	BAZA -	Mental Health
			0266 - NBHCNASJACKSONVILLE	BDZA -	Non-Primary Care
			0275 - NBHCALBANY	BGZA -	Primary Care
			0337 - NBHCKINGSBAY	BGZB -	
			0405 - NBHCMAYPORT	BGZC -	
			0517 - NBHCKEYWEST	BGZD -	

THIRD NEXT AVAILABLE REPORT - DAILY
4 BY APPOINTMENT TYPE WEIGHTED AVERAGE R

DAILY 6/27/2018

DMIS Facility Name	24HR Days Til	24HR Pass Rate	ACUT Days Til	ACUT Pass Rate	OPAC Days Til	OPAC Pass Rate	EST Days Til	EST Pass Rate	FTR Days Til	FTR Pass Rate	ROUT Days Til	ROUT Pass Rate	SPEC Days Til	SPEC Pass Rate	PCM Days Til	PCM Pass Rate	WELL Days Til	WELL Pass Rate
0039 - NHJACKSONVILLE																		
Primary Care																		
BAZA -	0.02	100.00%	0.00	0.00%	0.00	0.00%	0.00	0.00%	4.99	100.00%	0.00	0.00%	0.04	100.00%	0.00	0.00%	0.00	0.00%

Figure 3. Weekly Report Example



BOS: Navy | Command: NAVMED_E | Parent DMIS ID Facility: 0039 - NHJACKSONVILLE | DMIS ID Facility: 0035 - NBHCGROTON; 0038 - NHPENSACOLA; 0039 - NHJACKSONVILLE; 0056 - JAMESALOVELLFHCC; 0068 - NHCPATUXENTRIVER; 0091 - NHCAMPLEJEUNE | MEPRS4 Clinic: BAZA -; BDZA -; BGZA -; BGZB -; BGZC -; BGZD - | Care Type: Mental Health; Non-Primary Care; Primary Care

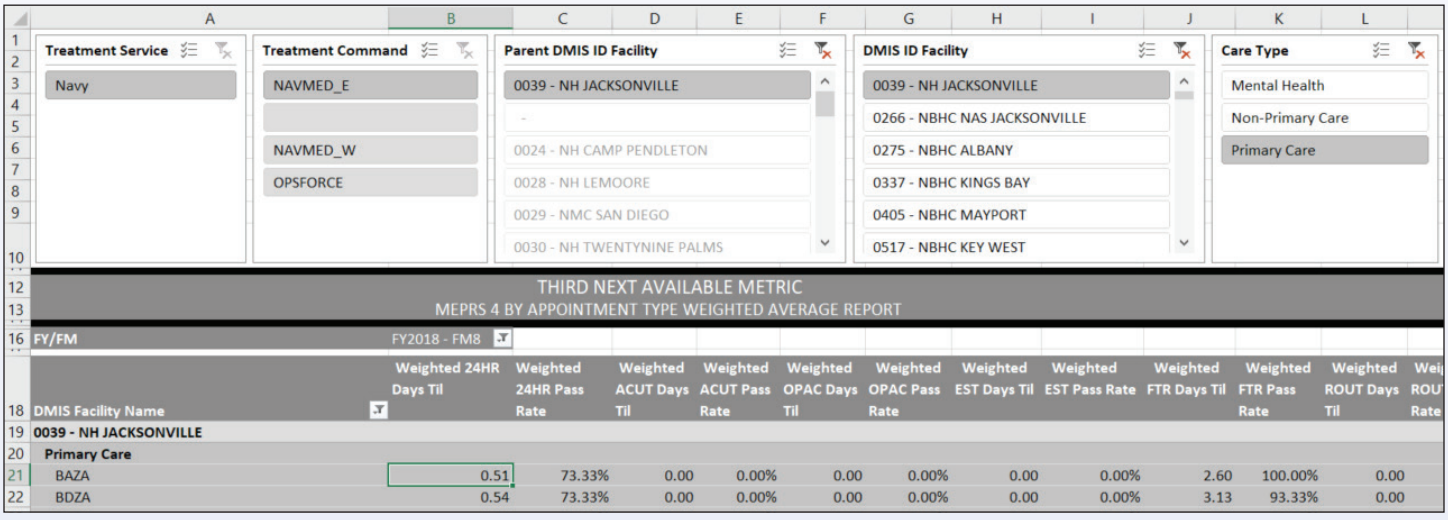
THIRD NEXT AVAILABLE REPORT - WEEKLY
MEPRS 4 BY APPOINTMENT TYPE WEIGHTED AVERAGE REPORT

Week: 04JUN2018-10JUN2018

DMIS Facility Name	24HR Days Til	24HR Pass Rate	ACUT Days Til	ACUT Pass Rate	OPAC Days Til	OPAC Pass Rate	EST Days Til	EST Pass Rate	FTR Days Til	FTR Pass Rate	ROUT Days Til	ROUT Pass Rate	SPEC Days Til	SPEC Pass Rate	PCM Days Til	PCM Pass Rate	WELL Days Til	WELL Pass Rate
0039 - NHJACKSONVILLE																		
Primary Care																		
BAZA -	0.46	71.43%	0.00	0.00%	0.00	0.00%	0.00	0.00%	2.66	100.00%	0.00	0.00%	1.89	100.00%	0.00	0.00%	0.00	0.00%
BDZA -	0.47	71.43%	0.00	0.00%	0.00	0.00%	0.00	0.00%	4.25	71.43%	0.00	0.00%	2.79	100.00%	0.00	0.00%	0.00	0.00%
BGZA -	0.53	71.43%	0.00	0.00%	0.00	0.00%	0.00	0.00%	2.77	100.00%	0.00	0.00%	0.00	0.00%	0.00	0.00%	0.00	0.00%
BGZB -	0.52	71.43%	0.00	0.00%	0.00	0.00%	0.00	0.00%	3.76	100.00%	0.00	0.00%	0.00	0.00%	0.00	0.00%	0.00	0.00%
BGZC -	0.84	42.86%	0.00	0.00%	0.00	0.00%	0.00	0.00%	13.41	14.29%	0.00	0.00%	2.54	100.00%	0.00	0.00%	0.00	0.00%
BGZD -	0.47	71.43%	0.00	0.00%	0.00	0.00%	0.00	0.00%	2.59	100.00%	0.00	0.00%	2.96	100.00%	0.00	0.00%	0.00	0.00%

... | PDMIS and DMIS by Appt Type | MEPRS4 by Appt Type | BOS by ATC Categ | Command by ATC Categ | PDMIS and DMIS by ATC Category | MEPRS4 by ATC Category | raw ...

Figure 4. Monthly Report Example



Treatment Service: Navy | Treatment Command: NAVMED_E; NAVMED_W; OPSFORCE | Parent DMIS ID Facility: 0039 - NH JACKSONVILLE; 0024 - NH CAMP PENDLETON; 0028 - NH LEMOORE; 0029 - NMC SAN DIEGO; 0030 - NH TWENTYNINE PALMS | DMIS ID Facility: 0039 - NH JACKSONVILLE; 0266 - NBHC NAS JACKSONVILLE; 0275 - NBHC ALBANY; 0337 - NBHC KINGS BAY; 0405 - NBHC MAYPORT; 0517 - NBHC KEY WEST | Care Type: Mental Health; Non-Primary Care; Primary Care

THIRD NEXT AVAILABLE METRIC
MEPRS 4 BY APPOINTMENT TYPE WEIGHTED AVERAGE REPORT

FY/FM: FY2018 - FM8

DMIS Facility Name	Weighted 24HR Days Til	Weighted 24HR Pass Rate	Weighted ACUT Days Til	Weighted ACUT Pass Rate	Weighted OPAC Days Til	Weighted OPAC Pass Rate	Weighted EST Days Til	Weighted EST Pass Rate	Weighted FTR Days Til	Weighted FTR Pass Rate	Weighted ROUT Days Til	Weighted ROUT Pass Rate
0039 - NH JACKSONVILLE												
Primary Care												
BAZA	0.51	73.33%	0.00	0.00%	0.00	0.00%	0.00	0.00%	2.60	100.00%	0.00	
BDZA	0.54	73.33%	0.00	0.00%	0.00	0.00%	0.00	0.00%	3.13	93.33%	0.00	

PCM Continuity

The TOC's PCM Continuity report shows the ratio of the number of appointments where patients see their assigned PCM divided by the total number of primary care appointments. A patient has seen his or her PCM if the provider ID (PROVID) of the provider seen matches the patient's PCM ID from CHCS (CHCS_PCM) at the time of the appointment. The PCM Continuity report does not include sites that have transitioned to MHS Genesis starting one month prior to when the MTF transitioned.

The TOC prepares the PCM Continuity report for clinic's overall each month and a weekly and monthly view of PCM Team continuity (Figure 5). The overall monthly PCM continuity report can be drilled down to the enrollment team and provider level using drop down menus above and within the report (Figure 6). The team reports can be drilled down from the Service to the individual provider and display compliance by appointment type or program category.

For more information on any report or to download report from the TOC, please visit the TOC website: https://mhs.health.mil/toc/.

Figure 5. PCM Continuity Report Example

BOS	DMIS ID	FacilityName
Navy	0024	NHC LEMOORE
Air Force	0026	ACH BASSETT-WAINWRIGHT
Army	0028	ACH BAYNE-JONES-POLK
NCRMD	0029	ACH BLANCHFIELD-CAMPBELL
	0030	ACH BRIAN ALLGOOD-SEOUL

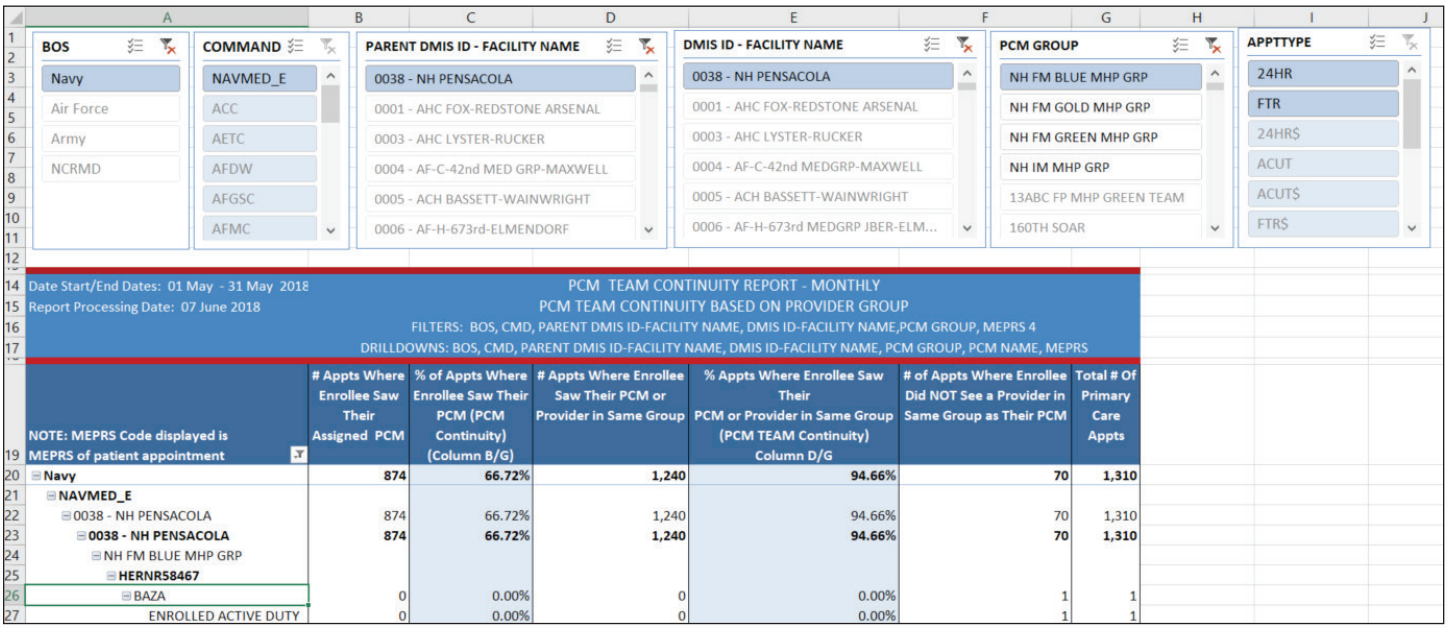
Start/End Dates: 1 May - 31 May 2018

PCM Continuity Metric

Parent DMIS ID (All)

FacilityName	Total Appts	Seen by PCM	% of PCM Continuity
Navy	**2,763**	**1,358**	**49.1%**
0028 NHC LEMOORE	2,763	1,358	49.1%
LE FLEET MEDHOME	**1,081**	**322**	**29.8%**
AICHJ23386			
BGZJ	184	71	38.6%
BAHOS25669			

Figure 6. PCM Team Continuity Report Example



BOS	COMMAND	PARENT DMIS ID - FACILITY NAME	DMIS ID - FACILITY NAME	PCM GROUP	APPTTYPE
Navy	NAVMED_E	0038 - NH PENSACOLA	0038 - NH PENSACOLA	NH FM BLUE MHP GRP	24HR
Air Force	ACC	0001 - AHC FOX-REDSTONE ARSENAL	0001 - AHC FOX-REDSTONE ARSENAL	NH FM GOLD MHP GRP	FTR
Army	AETC	0003 - AHC LYSTER-RUCKER	0003 - AHC LYSTER-RUCKER	NH FM GREEN MHP GRP	24HR$
NCRMD	AFDW	0004 - AF-C-42nd MED GRP-MAXWELL	0004 - AF-C-42nd MEDGRP-MAXWELL	NH IM MHP GRP	ACUT
	AFGSC	0005 - ACH BASSETT-WAINWRIGHT	0005 - ACH BASSETT-WAINWRIGHT	13ABC FP MHP GREEN TEAM	ACUT$
	AFMC	0006 - AF-H-673rd-ELMENDORF	0006 - AF-H-673rd MEDGRP JBER-ELM...	160TH SOAR	FTR$

Date Start/End Dates: 01 May - 31 May 2018
Report Processing Date: 07 June 2018

PCM TEAM CONTINUITY REPORT - MONTHLY
PCM TEAM CONTINUITY BASED ON PROVIDER GROUP
FILTERS: BOS, CMD, PARENT DMIS ID-FACILITY NAME, DMIS ID-FACILITY NAME,PCM GROUP, MEPRS 4
DRILLDOWNS: BOS, CMD, PARENT DMIS ID-FACILITY NAME, DMIS ID-FACILITY NAME, PCM GROUP, PCM NAME, MEPRS

NOTE: MEPRS Code displayed is MEPRS of patient appointment	# Appts Where Enrollee Saw Their Assigned PCM	% of Appts Where Enrollee Saw Their PCM (PCM Continuity) (Column B/G)	# Appts Where Enrollee Saw Their PCM or Provider in Same Group	% Appts Where Enrollee Saw Their PCM or Provider in Same Group (PCM TEAM Continuity) Column D/G	# of Appts Where Enrollee Did NOT See a Provider in Same Group as Their PCM	Total # Of Primary Care Appts
Navy	**874**	**66.72%**	**1,240**	**94.66%**	**70**	**1,310**
NAVMED_E						
0038 - NH PENSACOLA	874	66.72%	1,240	94.66%	70	1,310
0038 - NH PENSACOLA	**874**	**66.72%**	**1,240**	**94.66%**	**70**	**1,310**
NH FM BLUE MHP GRP						
HERNR58467						
BAZA	0	0.00%	0	0.00%	1	1
ENROLLED ACTIVE DUTY	0	0.00%	0	0.00%	1	1

NEW KNOWLEDGE

– COMPARATIVE DATA SOURCES

This section provides an overview of the Access Monitoring System (AMS), which is used to alert the Centers for Medicare and Medicaid Services (CMS) to potential reductions in access to care experienced by Medicare beneficiaries.

CMS Access Monitoring System Dashboard .

The CMS Access Monitoring System (AMS) dashboard presents visualizations of access to care for fee-for-service (FFS) Medicare beneficiaries. The dashboard displays beneficiary and provider measures at national, CMS region, state, and county levels from 2008 to the current year at annual and quarterly intervals. In turn, these measurements can be used to detect any significant changes in access relative to national averages and over time.

Indicators are categorized into access domains under the following four groups:

Realized Access:

- **Population-Based Indicators** – measures based on denominators of eligible beneficiaries provide some sense of realized access among the entire population for both users and non-users.
- **Provider-Based Indicators** – measures based on services provided by any eligible professional reveal changes in provider supply and availability.
- **Access to Preventive Care and Services** – measures based on rates of beneficiaries who received preventive exams and services reveal any change in services to patients who should receive them.

Perceptions and Concerns about Access:

- **Self-reported Perceptions of Access** – measures of beneficiary perceptions and concerns about access can be used to supplement utilization data to determine if a reported need for additional access to providers is reflected as a decrease in realized access and vice versa.

The public dashboard can be accessed at https://www.ccwdata.org/web/guest/interactive-data/ams-dashboard.

TIPS AND TRICKS

– *ACCESS TO CARE SUMMARY IN M2*

The official reporting for access to care performance measures is through the TRICARE Operations Center (TOC). However, in MHS Mart (M2), there is a new corporate report that is similar to the Access to Care (ATC) Summary on the TOC website. This report can be used in conjunction with the TOC reports and allows users to do custom drill downs or to limit access reporting to specific cohorts.

The "Access to Care Summary" file can be found in the Public Documents of BCS 4.2 (Figure 7). After logging in, navigate to Public Folders > BCS > M2 > TMA/HA > Financial Management > WEBI RC > Access to Care Summary.wid. Double click on file name to open query.

The corporate report is saved as a shell, so must be refreshed after opening query (Note: the refresh icon looks like two arrows going in a circle). This query can be run at "Enrollment Site" or "Enrollment Site Parent" level. Upon refreshing, you will be prompted for "Enrollment Site Parent ID" and "Enrollment Site" (Figure 8). Answer only for the one you are interested in and leave the other blank. You will also be prompted for "FY" which you are required to answer. Click OK after answering prompts.

Figure 7. BCS 4.2 – "Access to Care Summary" Corporate Report Location

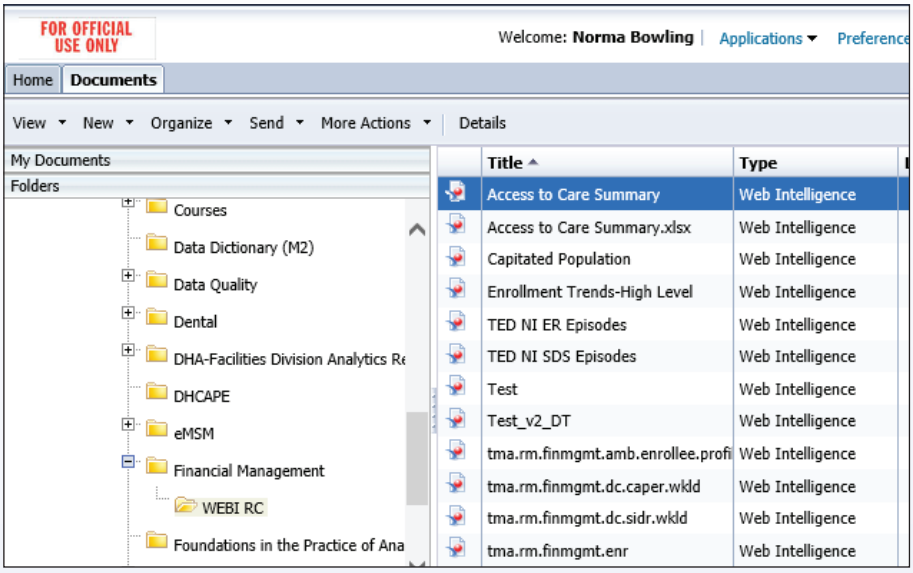
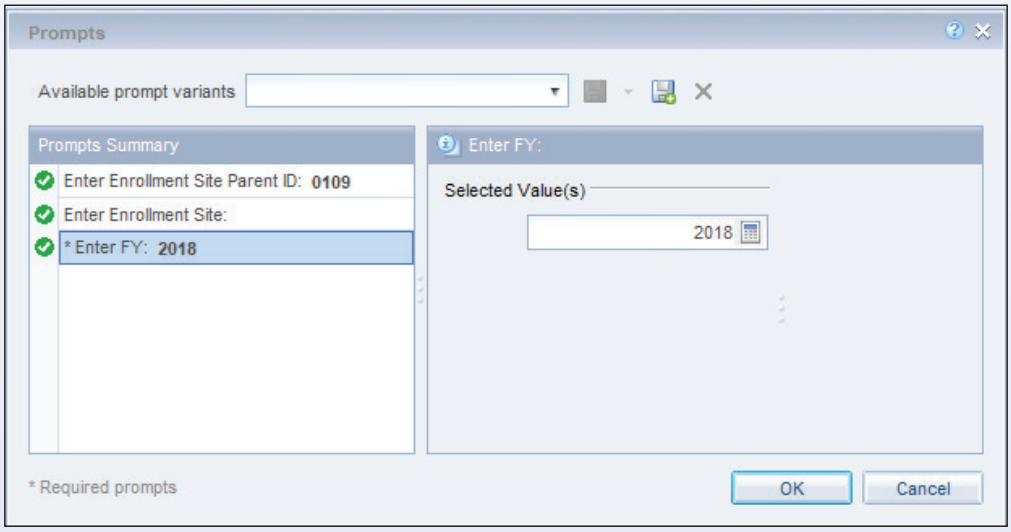


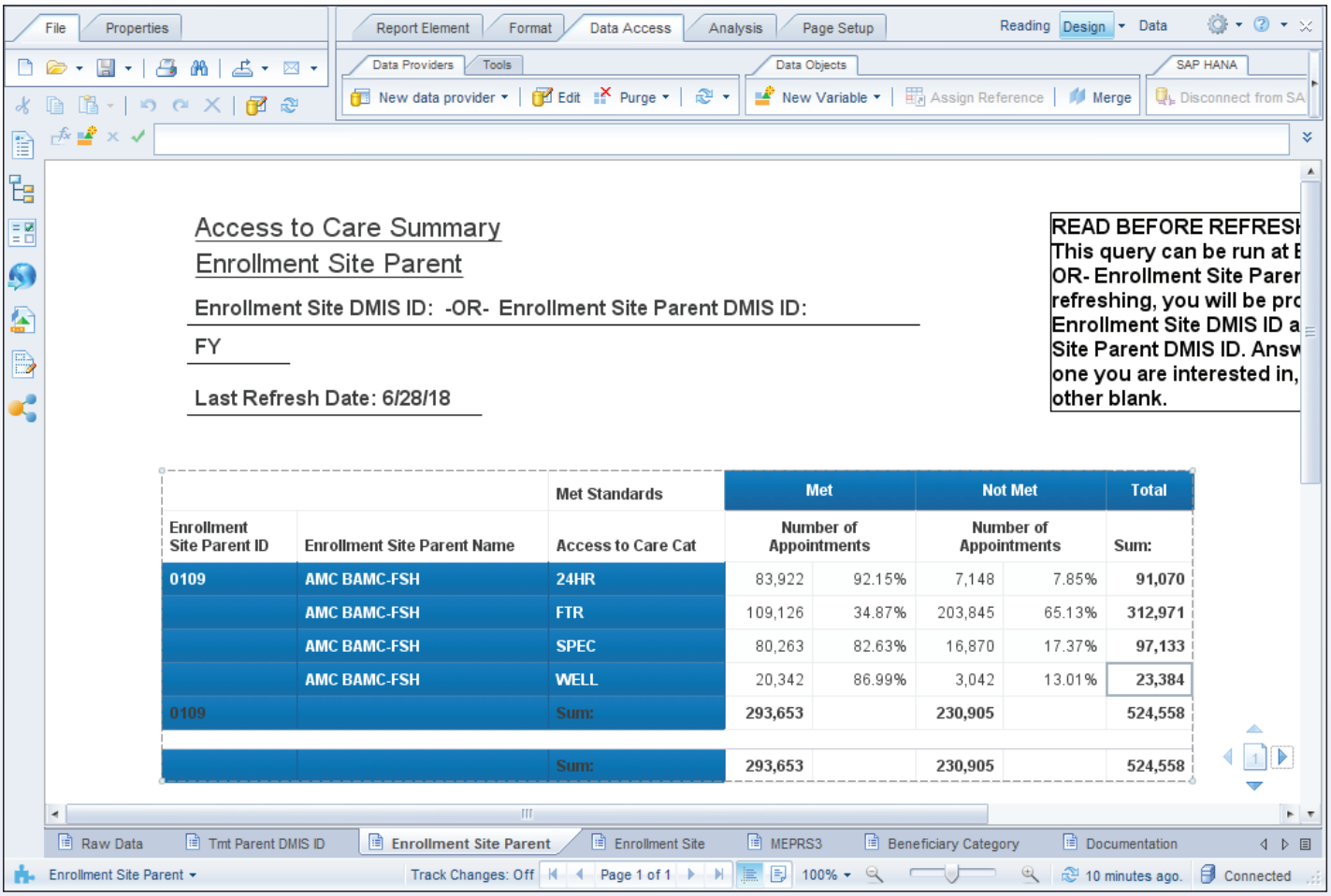
Figure 8. Prompt Box upon Refreshing Access to Care Summary Query



Note that this report has several tabs available (Figure 9). The "Raw Data" tab contains the raw data pulled in the query. The "Documentation" tab gives the user a summary of the prompts and of the queries. You will see information such as the last refresh date, the number of rows pulled, and the variables selected to the prompts.

The remaining tabs show the results stratified at different levels such as "Tmt Parent DMIS ID", "Enrollment Site", "MEPRS3", and "Beneficiary Category". When you select a tab, you will see the data presented in a cross tab showing the access to care categories, the number of appointments met or unmet, along with the percentages associated with each and a total number of appointments.

Figure 9. Results at the Enrollment Site Parent Level for BAMC (0109) in FY 2018

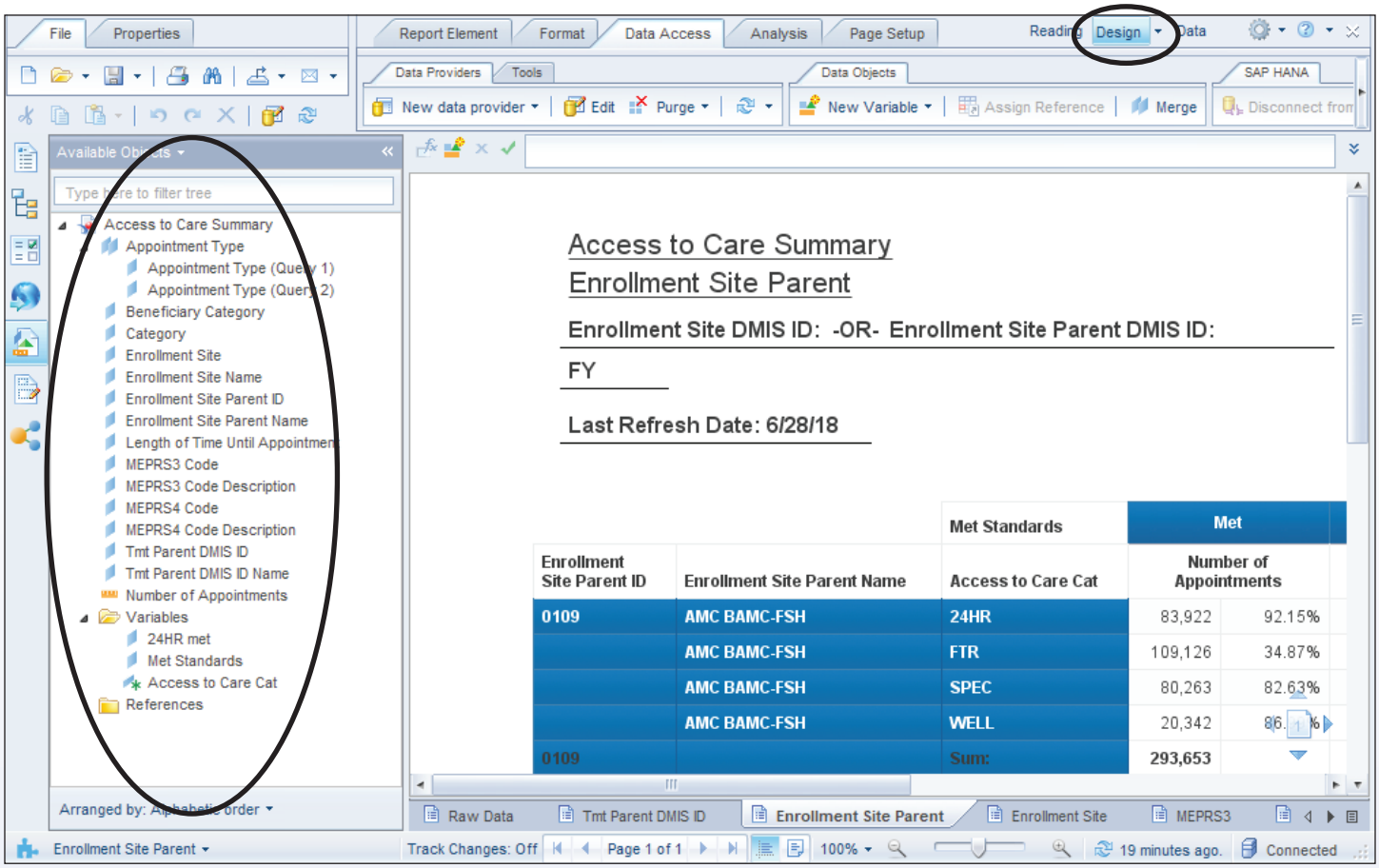


		Met Standards	Met		Not Met		Total
Enrollment Site Parent ID	Enrollment Site Parent Name	Access to Care Cat	Number of Appointments		Number of Appointments		Sum:
0109	AMC BAMC-FSH	24HR	83,922	92.15%	7,148	7.85%	91,070
	AMC BAMC-FSH	FTR	109,126	34.87%	203,845	65.13%	312,971
	AMC BAMC-FSH	SPEC	80,263	82.63%	16,870	17.37%	97,133
	AMC BAMC-FSH	WELL	20,342	86.99%	3,042	13.01%	23,384
0109		Sum:	293,653		230,905		524,558
		Sum:	293,653		230,905		524,558

If the information the user wants to see is not available in one of the tabs, then the user may modify the results to add what they want to see.

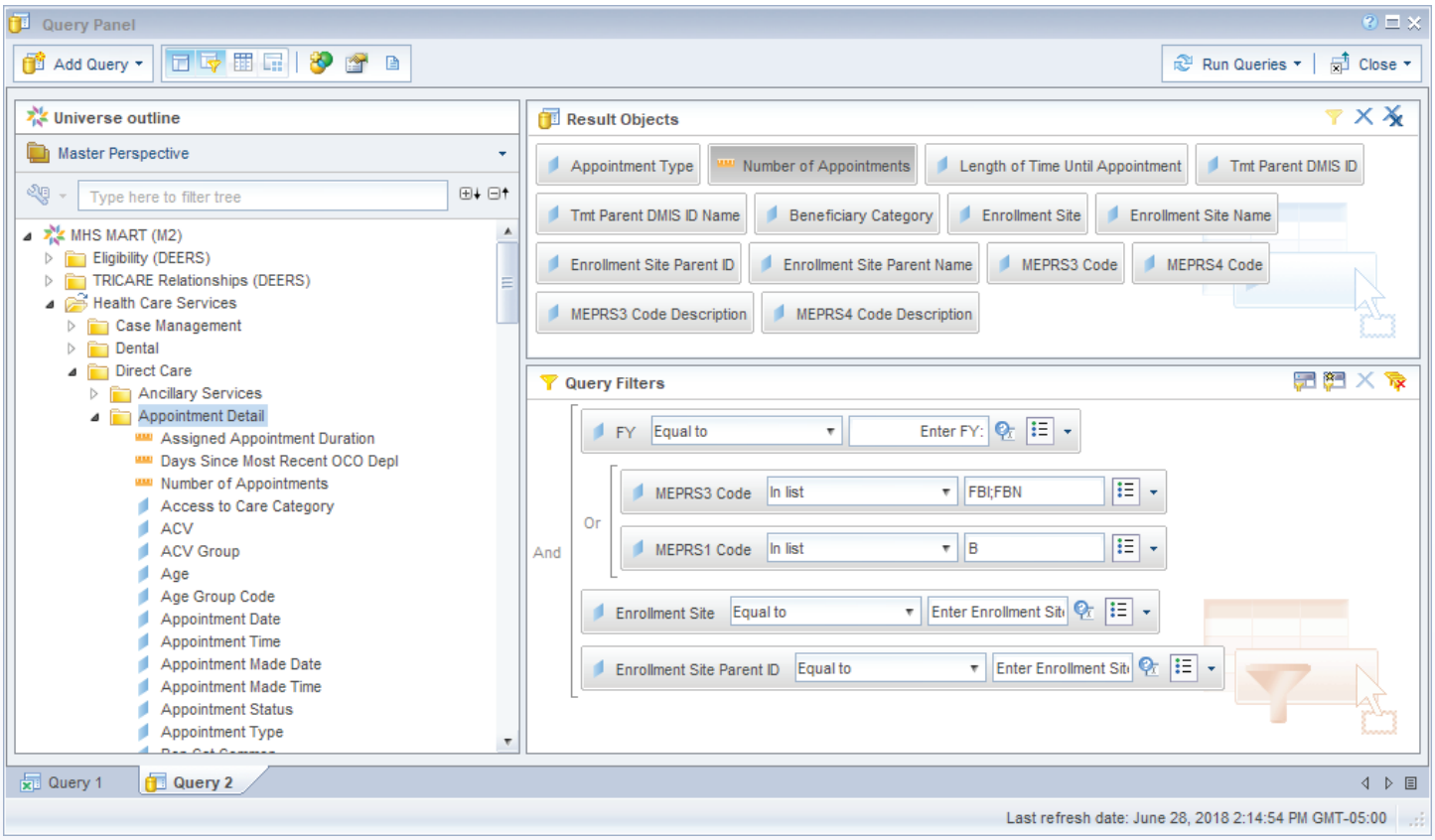
First, to make any changes or modifications to query you must click on "Design" in the top right corner of the screen (Figure 10). Look to see if the variable you want to add is in the Available Objects on the left side of the window. If it is available, then the user may add it to an existing tab or add a new tab. You may add a new tab by right clicking on an existing tab and selecting "Add Report" (to add a new blank tab) or "Duplicate Report" (to duplicate an existing tab that may then be modified.)

Figure 10. List of Available Objects



You may like to add a variable that is not available in the list of objects. For example, if you would like to limit to a medical home and look at access by provider specialty. To do this, click on the "Edit" query icon (yellow barrel). This will open the query panel where result objects and query filters can be modified (Figure 11). Note for this particular report, you can only make changes to Query 2 in the query panel. The class that is being used (and the only one you can select from without causing an error) is MHS Mart (M2) > Health Care Services > Direct Care > Appointment Detail. Add the objects that you are interested in to the Result Objects window on the top right, modify the query filters if applicable, and rerun the query. After running query with your additional objects, you will need to add them into the report where desired. They will not be added automatically.

Figure 11. Query Panel



KNOWLEDGE SOURCES

— RECOMMENDED SERIALS

Analytics is ultimately applied to evaluate and effect change within our health care system. The following journal is recommended reading for those who wish to broaden their capabilities by acquiring a foundational understanding of current topics and issues in health services research, policy, and practice.

Medical Care Research and Review (MCRR) is a peer-reviewed journal that provides essential information about the field of health services to researchers, policy makers, managers, and practitioners. MCRR publishes peer-reviewed empirical and theoretical research, examining such issues as the organization and financing of health care delivery, the impact of health policy and practice changes, patient safety and quality of care, health information technology adoption and application to health delivery, access to care, health care disparities, and insurance coverage trends. The focus of the MCRR articles covers: particular research policy topics that comprehensively synthesize relevant theoretical and empirical literature across several disciplines; methodologically rigorous empirical research that provides a significant contribution to previous knowledge; and articles that present new data and trends in the health care field. Regular sections include:

- Empirical Research
- Data and Trends

MCRR is published bi-monthly. A subscription is necessary to receive the journal and to access current and archived articles online at http://mcr.sagepub.com. The website also offers the OnlineFirst feature, which releases electronic versions of articles before they are available in print.

IN THE NEXT ISSUE

The next issue of *Healthcare Analytics in Navy Medicine* will focus on Navy Medicine efforts around readiness at various levels in the context of evolving mission focus and responsibility, readiness assessment in a non-deployed environment, and better understanding of what must be measured and analyzed for continuous improvement. It will also discuss how appropriate data, metrics, and asking the right questions around readiness help ensure medical readiness to deploy and a medical force that is ready to deliver health care anytime, anywhere.

Editor:
Christine Nguyen and Sarah Cevallos,
Navy Bureau of Medicine and Surgery

Managing Editor:
C. Allison Russo, Dr.P.H.

Presentation Designer:
Liz Ritter

Contributors:
Allison Russo, Wendy Funk,
Norma Bowling, Keith Hofmann,
Tracy Comer, Mary Cohen,
and Arnie Brooks

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